

		FOR OHF USE					

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2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div>I. IDPH Facility ID Number: 0041343</div> <div>Facility Name: OAKWOOD TERRACE</div> <div>Address: 1300 OAK AVE. EVANSTON 60201</div> <div>County: COOK</div> <div>Telephone Number: (847) 869-1300 Fax # (847) 869-1378</div> <div>IDPA ID Number: 364041095001</div> <div>Date of Initial License for Current Owners: 01/01/96</div> <div>Type of Ownership:</div> <div><div><div><div></div><div>VOLUNTARY,NON-PROFIT</div><div>Charitable Corp.</div><div>Trust</div><div>IRS Exemption Code</div></div></div><div><div><div>X</div><div>PROPRIETARY</div><div>Individual</div><div>Partnership</div><div>Corporation</div><div>"Sub-S" Corp.</div><div>X Limited Liability Co.</div><div>Trust</div><div>Other</div></div></div><div><div><div></div><div>GOVERNMENTAL</div><div>State</div><div>County</div><div>Other</div></div></div></div> <div><div>In the event there are further questions about this report, please contact:</div><div>Name:: Steve Lavenda</div><div>Telephone Number: (847) 236 - 1111</div></div>	<div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div> <div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div> <div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div> <div><div>Officer or Administrator of Provider</div><div>(Signed)</div><div>(Type or Print Name)</div><div>(Title)</div></div> <div><div>Paid Preparer</div><div>(Signed) See Accountants' Compilation Report Attached</div><div>(Print Name and Title) CARY C. BUXBAUM, C.P.A.</div><div>(Firm Name &amp; Address) Frost, Ruttenberg &amp; Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax # (847) 236-1155</div></div> <div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKWOOD TERRACE

# 0041343 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	4	Skilled (SNF)	4	1,460	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	19,345	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,805	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	716	513		1,229	8
9	SNF/PED					9
10	ICF	9,516	6,329		15,845	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,232	6,842		17,074	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.07%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid? 87 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 1/1/96

J. Was the facility purchased or leased after January 1, 1978? YES X Date 1/1/96 NO

K. Was the facility certified for Medicare during the reporting year? YES NO X If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCUAL X MODIFIED CASH\* CASH\*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/02 Fiscal Year: 12/31/02

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OAKWOOD TERRACE # 0041343 Report Period Beginning: 01/01/02 Ending: 12/31/02

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	88,132	14,611	7,200	109,943		109,943	(5,068)	104,875			1
2	Food Purchase		94,853		94,853	(4,420)	90,433	(423)	90,010			2
3	Housekeeping	19,351	4,071		23,422		23,422	191	23,613			3
4	Laundry	19,576	4,540		24,116		24,116		24,116			4
5	Heat and Other Utilities			42,176	42,176		42,176	343	42,519			5
6	Maintenance	29,413	4,183	37,706	71,302		71,302	(3,483)	67,819			6
7	Other (specify):*							2,498	2,498			7
8	<b>TOTAL General Services</b>	156,472	122,258	87,082	365,812	(4,420)	361,392	(5,942)	355,450			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	635,336	33,161	60,031	728,528		728,528	(24,292)	704,236			10
10a	Therapy	18,954		6,132	25,086		25,086		25,086			10a
11	Activities	21,462	4,310	1,512	27,284		27,284		27,284			11
12	Social Services	17,701		6,182	23,883		23,883		23,883			12
13	Nurse Aide Training			245	245		245		245			13
14	Program Transportation											14
15	Other (specify):*							1,128	1,128			15
16	<b>TOTAL Health Care and Programs</b>	693,453	37,471	75,302	806,226		806,226	(23,164)	783,062			16
	<b>C. General Administration</b>											
17	Administrative	49,972			49,972		49,972	30,071	80,043			17
18	Directors Fees											18
19	Professional Services			50,685	50,685	(1,867)	48,818	(21,704)	27,114			19
20	Dues, Fees, Subscriptions & Promotions			27,854	27,854		27,854	(15,334)	12,520			20
21	Clerical & General Office Expenses	22,722	19,375	11,983	54,080		54,080	14,870	68,950			21
22	Employee Benefits & Payroll Taxes			112,557	112,557	4,420	116,977		116,977			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,128	1,128		1,128	(80)	1,048			24
25	Other Admin. Staff Transportation			437	437		437	708	1,145			25
26	Insurance-Prop.Liab.Malpractice			30,389	30,389		30,389	306	30,695			26
27	Other (specify):*							8,205	8,205			27
28	<b>TOTAL General Administration</b>	72,694	19,375	235,033	327,102	2,553	329,655	17,042	346,697			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	922,619	179,104	397,417	1,499,140	(1,867)	1,497,273	(12,064)	1,485,209			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			48,619	48,619		48,619	107,012	155,631			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			188,215	188,215		188,215	132,711	320,926			32
33	Real Estate Taxes			101,523	101,523	1,867	103,390	1,585	104,975			33
34	Rent-Facility & Grounds			171,000	171,000		171,000	(171,000)				34
35	Rent-Equipment & Vehicles			1,090	1,090		1,090	2,081	3,171			35
36	Other (specify):*											36
37	TOTAL Ownership			510,447	510,447	1,867	512,314	72,389	584,703			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			517	517		517	(350)	167			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,207	31,207		31,207		31,207			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			31,724	31,724		31,724	(350)	31,374			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	922,619	179,104	939,588	2,041,311		2,041,311	59,975	2,101,286			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(50)	2		4
5	Telephone, TV & Radio in Resident Rooms	(242)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	47,243	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(373)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(950)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,513)	21		24
25	Fund Raising, Advertising and Promotional	(2,295)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,153)	20		28
29	Other-Attach Schedule	(40,154)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (15,487)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	75,462		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 75,462		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ 59,975		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
OAKWOOD TERRACE			
100	0041343		
Report Period Beginning: 01/01/02			
Ending: 12/31/02			
NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1 TRUST FEES	(155)	21	1
2 THEFT AND DAMAGE	(40)	21	2
3 BARBER AND BEAUTY INCOME	(250)	40	3
4 MISC CHARGES	(60)	21	4
5 SUPPLEMENT INCOME	(3,696)	01	5
6 DIAPER INCOME	(13,087)	10	6
7 JURY DUTY INCOME	(17)	10	7
8 PPA - CONTRACT NURSING	(14,960)	10	8
9 AMORTIZATION OF LOAN COSTS	(4,594)	36	9
10 2003 SEMINAR	(150)	24	10
11 CAPITALIZED R&M	(3,859)	06	11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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98			98
99			99
100			100
101 Total	(40,154)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKWOOD TERRACE

# 0041343

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(3,696)				(1,372)							(5,068)	1
2	Food Purchase	(423)											(423)	2
3	Housekeeping			191									191	3
4	Laundry													4
5	Heat and Other Utilities	(242)		239	346								343	5
6	Maintenance	(3,059)		169	1,720	(2,313)							(3,483)	6
7	Other (specify):*				262	2,236							2,498	7
8	TOTAL General Services	(7,420)		599	2,328	(1,449)							(5,942)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(28,070)			5,443			(1,665)					(24,292)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				1,128								1,128	15
16	TOTAL Health Care and Programs	(28,070)			6,571			(1,665)					(23,164)	16
	C. General Administration													
17	Administrative			4,408	2,362	23,301							30,071	17
18	Directors Fees													18
19	Professional Services			(26,647)	1,311	3,632							(21,704)	19
20	Fees, Subscriptions & Promotions	(15,398)		59	5								(15,334)	20
21	Clerical & General Office Expenses	(6,748)		14,747	6,871								14,870	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(150)		12	58								(80)	24
25	Other Admin. Staff Transportation			173	535								708	25
26	Insurance-Prop.Liab.Malpractice			129	177								306	26
27	Other (specify):*			2,859	1,552	3,794							8,205	27
28	TOTAL General Administration	(22,296)		(4,260)	12,871	30,727							17,042	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(57,786)		(3,661)	21,770	29,278		(1,665)					(12,064)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number      OAKWOOD TERRACE      #      0041343      Report Period Beginning:      01/01/02      Ending:      12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	47,243	58,282	628	859								107,012	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		131,407	319	985								132,711	32
33	Real Estate Taxes			566	1,019								1,585	33
34	Rent-Facility & Grounds		(171,000)										(171,000)	34
35	Rent-Equipment & Vehicles			856	1,225								2,081	35
36	Other (specify):*	(4,594)	4,594											36
37	TOTAL Ownership	42,649	23,283	2,369	4,088								72,389	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(350)											(350)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(350)											(350)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(15,487)	23,283	(1,292)	25,858	29,278		(1,665)					59,975	45



## VII. RELATED PARTIES

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

[illegible]

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ **X** YES ☐ NO

**If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.**

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	\$ 171,000	OAKWOOD CARE REAL ESTATE LLC	100.00%	\$	\$ (171,000)	1
2	V	30	DEPRECIATION		OAKWOOD CARE REAL ESTATE LLC	100.00%	58,282	58,282	2
3	V	36	AMORTIZATION		OAKWOOD CARE REAL ESTATE LLC	100.00%	4,594	4,594	3
4	V	32	INTEREST		OAKWOOD CARE REAL ESTATE LLC	100.00%	131,407	131,407	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 171,000			\$ 194,283	\$ * 23,283	14

**\* Total must agree with the amount recorded on line 34 of Schedule VI.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 191	\$ 191	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	239	239	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	169	169	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	4,408	4,408	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	683	683	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	59	59	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	14,747	14,747	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	12	12	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	173	173	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	129	129	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	2,859	2,859	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	628	628	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	319	319	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	566	566	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	856	856	29
30	V								30
31	V								31
32	V	19	ACCOUNT/BOOKKEEPING	27,330	PREFERRED BOOKKEEPING	100.00%		(27,330)	32
33	V	19	COMPUTER	1,368	PREFERRED BOOKKEEPING	100.00%	1,368		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 28,698			\$ 27,406	\$ * (1,292)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 346	\$ 346	15
16	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,720	1,720	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	262	262	17
18	V	10	NURSING		S.I.R. MANAGEMENT, INC.	100.00%	5,443	5,443	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,128	1,128	19
20	V	17	ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	2,362	2,362	20
21	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,311	1,311	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	5	5	22
23	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	6,871	6,871	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	58	58	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	535	535	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	177	177	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,552	1,552	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	859	859	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	985	985	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	1,019	1,019	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,225	1,225	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 25,858	\$ * 25,858	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,720	\$	1,720
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	356		356
17	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	10,777		10,777
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	3,632		3,632
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	1,839		1,839
20	V								20
21	V	17	ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%	7,066		7,066
22	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,134		1,134
23	V								23
24	V	17	ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%	5,458		5,458
25	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	821		821
26	V								26
27	V	10A	SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%			27
28	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			28
29	V								29
30	V	6	REPAIRS AND MAINT.	7,272	S.I.R. MANAGEMENT, INC.	100.00%	4,959		(2,313)
31	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,028		1,028
32	V								32
33	V	1	DIETICIAN SALARIES	7,200	S.I.R. MANAGEMENT, INC.	100.00%	4,108		(3,092)
34	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	852		852
35	V								35
36	V	19	LEGAL FEES		S.I.R. MANAGEMENT, INC.	100.00%			36
37	V								37
38	V	17	COUNCIL DUES		S.I.R. MANAGEMENT, INC.	100.00%			38
39	Total			\$ 14,472			\$ 43,750	\$ *	29,278

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 29,297	\$ 29,297	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	29,297	CCS EMPLOYEE BENEFIT GROUP	100.00%		(29,297)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 29,297			\$ 29,297	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	XCEL Medical Supply, LLC	100.00%	\$	\$	15
16	V	03	Housekeeping		XCEL Medical Supply, LLC	100.00%			16
17	V	10	Nursing	12,287	XCEL Medical Supply, LLC	100.00%	10,622	(1,665)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 12,287			\$ 10,622	\$ * (1,665)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	TOM WINTER	MEMBER	ADMIN.	3.51%	SEE ATTACHED	1.75	2.92%	Alloc.Salary	\$ 4,408	17-7	1
2	ARTURO ROMINIQUIT	RELATIVE	CLERICAL	0	SEE ATTACHED	1.07	2.92%	Alloc.Salary	689	21-7	2
3	BRYAN BARRISH		ADMIN.	0	SEE ATTACHED	1.49	4.26%	Alloc.Salary	7,066	17-7	3
4	MIKE GIANNINI		ADMIN.	0	SEE ATTACHED	1.7	4.25%	Alloc.Salary	5,458	17-7	4
5	LOUISE BERGTHOLD	MEMBER	ADMIN.	3.51%	SEE ATTACHED	1.53	2.78%	Alloc.Salary	4,938	17-7	5
6	NENITA GUZMAN	RELATIVE	ADMIN.	0	SEE ATTACHED	1.39	2.78%	Alloc.Salary	1,720	1-7	6
7	ERIC ROTHNER	MEMBER	ADMIN.	14.04%	SEE ATTACHED	0.17	0.01%	Alloc.Salary	489	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 24,768		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OAKWOOD TERRACE # 0041343 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**Ending: 12/31/02**

(847) 674-5267

**SEE ACCOUNTANTS' COMPILATION REPORT**

**Ending: 12/31/02**

( 847) 675 -0555

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number      OAKWOOD TERRACE      #    0041343    Report Period Beginning:      01/01/02      Ending:    12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☒      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization      S.I.R. MANAGEMENT, INC.  
Street Address      6840 N. LINCOLN  
City / State / Zip Code      LINCOLNWOOD, IL. 60712  
Phone Number      ( 847) 675 -7979  
Fax Number      ( 847) 675 -0555

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	628,177	10	\$ 62,004	\$ 62,004	17,422	\$ 1,720	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	628,177	10	12,854		17,422	356	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	628,177	10	388,593	388,593	17,422	10,777	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	628,177	10	130,972		17,422	3,632	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	628,177	10	\$ 66,321	\$	17,422	\$ 1,839	5
6										6
7	17	ADMIN. SALARY	AVG HRS WKD	35	10	165,979	165,979	1	7,066	7
8	27	EMP. BEN.-ADMIN.	AVG HRS WKD	35	10	26,644		1	1,134	8
9						\$	\$		\$	9
10	17	ADMIN SALARY	AVG HRS WKD	40	10	128,429	128,429	2	5,458	10
11	27	EMP. BEN.-ADMIN.	AVG HRS WKD	40	10	19,310		2	821	11
12										12
13	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	\$ 60,726	\$ 60,726		\$	13
14	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	12,589				14
15										15
16	6	REPAIRS AND MAINT.	MAINTENANCE INC.	177,156	10	120,809	120,809	7,272	4,959	16
17	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	177,156	10	25,044		7,272	1,028	17
18										18
19	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	71,551	71,551	7,200	4,108	19
20	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	14,833		7,200	852	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,306,658	\$ 998,091		\$ 43,750	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKWOOD TERRACE # 0041343 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
Street Address 4101 W. MAIN ST.  
City / State / Zip Code SKOKIE, IL 60076  
Phone Number ( 847) 674-1180  
Fax Number ( 847) 673-7741

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			\$	\$		\$ 29,297	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 29,297	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number OAKWOOD TERRACE # 0041343 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization XCEL MEDICAL SUPPLY, LLC  
Street Address 2201 MAIN STREET  
City / State / Zip Code EVANSTON, IL 60202  
Phone Number ( 847)328-7600  
Fax Number ( 847)3287615

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			\$	\$			1
2	03	Housekeeping	Direct Allocation							2
3	10	Nursing	Direct Allocation						10,622	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		10,622	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKWOOD TERRACE # 0041343 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKWOOD TERRACE # 0041343 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKWOOD TERRACE # 0041343 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKWOOD TERRACE # 0041343 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**12/31/02**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

<b>16)</b> Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	<b>\$ 0</b>	<b>Line #</b>	<b>N/A</b>
-----------------------------------------------------------------------------------------------------------------------	-------------	---------------	------------

\* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.**  
**(See instructions.)**

**\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOC. PREFERRED BKKP		X				\$				\$ 319	1
2	ALLOC. S.I.R. MGMT		X								985	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$	\$			\$ 1,304	21

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$	123,000		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	112,108		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(10,892)		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	114,000		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	1,867		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	104,975		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997		8	
		1998		9	
		1999	116,996	10	
		2000	119,181	11	
		2001	110,523	12	
<b>CALCULATION OF ACCRUAL = 2001 TAX x 1.03</b>					
<b>110523 x 1.03 = 114000 (ROUNDED)</b>					
<b>ALLOC. S.I.R. MANAGEMENT - \$1019</b>					
<b>ALLOC. PREFERRED BOOKKEEPING - \$566</b>					
		13	FROM R. E. TAX STATEMENT FOR 2001 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**



IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

OAKWOOD TERRACE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0041343

CONTACT PERSON REGARDING THIS REPORT

STEVE LAVENDA

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

- A. Summary of Real Estate Tax Cost
- Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	11-18-326-011-000	LONG TERM CARE PROPERTY	\$ 110,522.89	\$ 110,522.89
2.	SEE ATTACHED	S.I.R. MANAGEMENT ALLOC	\$ 69,233.82	\$ 1,380.46
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 179,756.71	\$ 111,903.35

- B. Real Estate Tax Cost Allocations
- Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    ☒ YES    ☐ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)
- C. Tax Bills
- Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

OAKWOOD TERRACE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0041343

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( )

FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?      YES      NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,609

B. General Construction Type: Exterior BRICK

Frame

Number of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1996	\$ 150,000	1
2					2
3	TOTALS			\$ 150,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	101,705		20	5,087	5,087	33,532	9
10	Various			1997	88,164		20	4,412	4,412	25,815	10
11	Various			1998	11,669		20	583	583	2,795	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,780,826	45,728		53,458	7,730	374,504	68
69	Financial Statement Depreciation			30,007			(30,007)		69
70	TOTAL (lines 4 thru 69)		\$ 1,982,364	\$ 75,735		\$ 63,540	\$ (12,195)	\$ 436,646	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,982,364	\$ 75,735		\$ 63,540	\$ (12,195)	\$ 436,646	1
2	SEWER WORK	1999	3,800		20	190	190	681	2
3	CARPETING	2000	3,801		20	190	190	428	3
4	PHONE SYSTEM	2000	2,745		20	137	137	297	4
5	WIRING	2000	2,838		20	142	142	367	5
6	STOWELL CONSTR	2000	930,164		20	46,508	46,508	96,892	6
7	ARCHITECT FEES	2000	64,260		20	3,213	3,213	6,694	7
8	SPRINKLER	2000	2,650		20	133	133	277	8
9	FIRE DOORS	2001	3,504		20	175	175	292	9
10	EXHAUST SYSTEM	2001	2,215		20	111	111	167	10
11	SHOWER ROOM	2001	5,672		20	284	284	355	11
12	FLOOR TILE	2001	3,769		20	188	188	219	12
13	A/C WIRING	2001	878		20	44	44	62	13
14	A/C WIRING	2001	1,791		20	90	90	128	14
15	PAINTING	2001	1,474		20	74	74	123	15
16	EJECTOR PUMP	2001	1,150		20	58	58	97	16
17	ARCHITTECT FEES	2001	2,800		20	140	140	280	17
18	EJECTOR PUMP	2002	6,100		20	407	407	407	18
19	WINDOWS	2002	925		20	46	46	46	19
20	HYDROJET SEWER	2002	3,200		20	160	160	160	20
21	SHOWER REPAIRS	2002	1,360		20	68	68	68	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,460	\$ 75,735		\$ 115,898	\$ 40,163	\$ 544,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57		1996	1996	\$ 1,757,500	\$ 44,895	35	\$ 52,500	\$ 7,605	\$ 367,500	4
5			1993	1993	7,411	235	35	212	(23)	2,011	5
6			1993	1993	4,114	131	35	118	(13)	1,117	6
7											7
8											8
	Improvement Type**										
9	ALLOC. PREFERRED BOOKKEEPING			1997	5,138	115	20	257	142	1,492	9
10	ALLOC. PREFERRED BOOKKEEPING			1999	41	-	20	2	2	7	10
11	ALLOC. PREFERRED BOOKKEEPING			2000	258	-	20	49	49	117	11
12											12
13	ALLOC. S.I.R. MANAGEMENT			1993	3,183	89	20	161	72	1,576	13
14	ALLOC. S.I.R. MANAGEMENT			1994	10	-	20	1	1	8	14
15	ALLOC. S.I.R. MANAGEMENT			1995	73	-	20	4	4	27	15
16	ALLOC. S.I.R. MANAGEMENT			1999	346	12	20	17	5	56	16
17	ALLOC. S.I.R. MANAGEMENT			2000	209	22	20	10	(12)	28	17
18											18
19	ALLOC. S.I.R. PROPERTIES - S.I.R. MANAGEMENT			1993	120	3	20	6	3	57	19
20	ALLOC. S.I.R. PROPERTIES - S.I.R. MANAGEMENT			1994	71	2	20	4	2	30	20
21	ALLOC. S.I.R. PROPERTIES - S.I.R. MANAGEMENT			1997	28	3	20	1	(2)	9	21
22	ALLOC. S.I.R. PROPERTIES - S.I.R. MANAGEMENT			1998	449	45	20	22	(23)	101	22
23	ALLOC. S.I.R. PROPERTIES - S.I.R. MANAGEMENT			1999	939	94	20	47	(47)	164	23
24	ALLOC. S.I.R. PROPERTIES - S.I.R. MANAGEMENT			2002	29	-	20	1	1	1	24
25											25
26	ALLOC. S.I.R. PROPERTIES - PREFERRED BOOKKEEPING			1993	67	2	20	3	1	32	26
27	ALLOC. S.I.R. PROPERTIES - PREFERRED BOOKKEEPING			1994	39	1	20	2	1	17	27
28	ALLOC. S.I.R. PROPERTIES - PREFERRED BOOKKEEPING			1997	15	2	20	1	(1)	5	28
29	ALLOC. S.I.R. PROPERTIES - PREFERRED BOOKKEEPING			1998	249	25	20	12	(13)	56	29
30	ALLOC. S.I.R. PROPERTIES - PREFERRED BOOKKEEPING			1999	521	52	20	26	(26)	91	30
31	ALLOC. S.I.R. PROPERTIES - PREFERRED BOOKKEEPING			2002	16	-	20	2	2	2	31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$        1,780,826	\$        45,728		\$        53,458	\$        7,730	\$        374,504	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 389,857	\$ 31,629	\$ 38,929	\$ 7,300	10	\$ 241,270	71
72	Current Year Purchases	9,720	1,027	804	(223)	10	3,282	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 399,577	\$ 32,656	\$ 39,733	\$ 7,077		\$ 244,552	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,577,037	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 108,391	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 155,631	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 47,243	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 789,238	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?  
☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 2,494 Description: \$1066 - COPIES; \$24 - AIR BED; ALLOC PREFERRED - \$179; ALLOC. S.I.R. - \$1225  
(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning  
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ALLOC. PREFERRED BOOKKEEPING		\$	\$ 677	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 677	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☒

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$243

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$220	\$	\$220
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		25		25
9	TOTALS	\$	\$245	\$	\$245
10	SUM OF line 9, col. 1 and 2 (e)	\$	245		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 22,934	\$ 23,361	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	475,064	475,064	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,454	5,454	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See Supplemental Schedule</a>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 503,452	\$ 503,879	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		1,757,500	14
15	Leasehold Improvements, at Historical Cost	1,173,234	1,173,234	15
16	Equipment, at Historical Cost	290,449	440,449	16
17	Accumulated Depreciation (book methods)	(347,642)	(810,929)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		22,216	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(15,315)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Supplemental Schedule</a>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,116,041	\$ 2,717,155	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,619,493	\$ 3,221,034	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 33,354	\$ 33,354	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,143	17,143	28
29	Short-Term Notes Payable	2,110,000	2,110,000	29
30	Accrued Salaries Payable	59,964	59,964	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,267	5,267	31
32	Accrued Real Estate Taxes(Sch.IX-B)	114,000	114,000	32
33	Accrued Interest Payable	6,239	10,139	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Supplemental Schedule</a>	481	481	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,346,448	\$ 2,350,348	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	794,647	794,647	39
40	Mortgage Payable	666,139	2,337,331	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Supplemental Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,460,786	\$ 3,131,978	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,807,234	\$ 5,482,326	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,187,741)	\$ (2,261,292)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,619,493	\$ 3,221,034	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (2,068,426)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (2,068,426)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(119,315)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (119,315)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (2,187,741)</b>	<b>24</b>

\*

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 1,881,925	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,881,925	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	360	6
7	Oxygen	1,462	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,822	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	243	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	350	13
14	Non-Patient Meals	50	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	28,311	21
22	Laundry	8,996	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 37,950	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Supplemental Schedule</a>	299	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 299	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,921,996	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	365,812	31
32	Health Care	806,226	32
33	General Administration	327,102	33
	<b>B. Capital Expense</b>		
34	Ownership	510,447	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	517	35
36	Provider Participation Fee	31,207	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,041,311	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(119,315)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (119,315)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? [See Attached](#) If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,897	2,014	\$ 54,553	\$ 27.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,379	5,539	118,866	21.46	3
4	Licensed Practical Nurses	6,674	6,735	129,037	19.16	4
5	Nurse Aides & Orderlies	29,312	30,255	274,990	9.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,996	2,060	18,954	9.20	8
9	Activity Director	464	627	7,368	11.75	9
10	Activity Assistants	2,146	2,203	14,094	6.40	10
11	Social Service Workers	1,449	1,578	17,701	11.22	11
12	Dietician					12
13	Food Service Supervisor	2,036	2,137	26,737	12.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,609	8,782	61,395	6.99	15
16	Dishwashers					16
17	Maintenance Workers	1,974	2,086	29,413	14.10	17
18	Housekeepers	3,036	3,124	19,351	6.19	18
19	Laundry	3,062	3,110	19,576	6.29	19
20	Administrator	1,869	2,086	49,972	23.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,699	2,837	22,722	8.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,348	2,372	57,890	24.41	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	74,950	77,545	\$ 922,619 *	\$ 11.90	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	\$ 7,200	01-03	35
36	Medical Director	MONTHLY	1,200	09-03	36
37	Medical Records Consultant	MONTHLY	4,472	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	900	10-03	39
40	Physical Therapy Consultant	21	1,004	10a-03	40
41	Occupational Therapy Consultant	105	5,028	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	100	10a-03	43
44	Activity Consultant	32	1,512	11-03	44
45	Social Service Consultant	127	4,982	12-03	45
46	Other(specify)				46
47	<u>PSYCHO-SOCIAL</u>	MONTHLY	1,200	12-03	47
48					48
49	TOTAL (lines 35 - 48)	287	\$ 27,598		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	715	\$ 54,546	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	98	113	10-03	52
53	TOTAL (lines 50 - 52)	813	\$ 54,659		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description	Amount
LEIF WOODHOUSE	ADMINISTRATOR	0	\$ 49,972	Workers' Compensation Insurance		\$ 12,391	IDPH License Fee	\$
				Unemployment Compensation Insurance		6,857	Advertising: Employee Recruitment	7,109
				FICA Taxes		69,718	Health Care Worker Background Check (Indicate # of checks performed <u>95</u> )	659
				Employee Health Insurance		20,451	ADVERTISING AND PROMOTION	2,295
				Employee Meals		4,420	YELLOW PAGE ADVERTISING	12,153
				Illinois Municipal Retirement Fund (IMRF)*			LICENSES AND PERMITS	4,689
				401K MATCHING		1,350	ALLOC. PREFERRED BOOKKEEPING	58
				OTHER EMPLOYEE BENEFITS		1,790	ALLOC. S.I.R MANAGEMENT	5
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,972				Less: Public Relations Expense	(2,295)
B. Administrative - Other							Non-allowable advertising	( )
Description			Amount				Yellow page advertising	(12,153)
			\$				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,520
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 116,977	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
PERSONNEL PLANNERS	UNEMPLOYMENT CONS		\$ 1,365			\$	Out-of-State Travel	\$
PREFERRED BOOKKEEPING	COMPUTER SERVICES		1,368					
PREFERRED BOOKKEEPING	BOOKKEEPING SVCS		13,680				In-State Travel	
PREFERRED BOOKKEEPING	ACCOUNTING		13,650					
FR&R	ACCOUNTING		10,050				Seminar Expense	978
LTC SOLUTIONS	MDS SOFTWARE		1,300				ALLOC. PREFERRED BOOKKEEPING	12
ICS SOLUTIONS	INTERNET SUPPORT		150				ALLOC. - S.I.R. MANGEMENT	58
DPSI	PAYROLL		239				Entertainment Expense	( )
PROCLAIM	3RD PARTY ADJUSTMENTS		73				TOTAL (agree to Sch. V, line 24, col. 8)	
AMARI & LOCALLO	REAL ESTATE ASSESSMENT		1,867				TOTAL	\$ 1,048
SEE ATTACHED SCHEDULE	LEGAL		6,943					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 50,685	TOTAL			\$	

**\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT**

**\*\*See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		OAKWOOD TERRACE		STATE OF ILLINOIS				Page 23
		#	0041343	Report Period Beginning:	01/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2)

Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount.

NO

(3)

Did the nursing home make political contributions or payments to a political action organization?  
If YES, have these costs been properly adjusted out of the cost report?

YES  
YES

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  
If YES, what is the capacity?

NO

(5)

Have you properly capitalized all major repairs and equipment purchases?  
What was the average life used for new equipment added during this period?

YES  
10 YRS

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 16,704 Line 10-2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  
If NO, attach a complete explanation.

YES

(8)

Are you presently operating under a sale and leaseback arrangement?  
If YES, give effective date of lease.

NO  
N/A

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?  
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X  
N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.  
This amount is to be recorded on line 42 of Schedule V.

\$ 31,207

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  
If YES, attach an explanation of the allocation.

NO

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

N/A

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?  
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)  
If YES, attach a schedule which explains how all related costs were allocated to these functions.

NO

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.  
Has any meal income been offset against related costs?

\$ 4,420  
NO  
Indicate the amount. \$ N/A

(16)

Travel and Transportation  
a. Are there costs included for out-of-state travel?  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents?  
If YES, please indicate the amount of income earned from such a program during this reporting period.  
c. What percent of all travel expense relates to transportation of nurses and patients?  
d. Have vehicle usage logs been maintained?  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

NO  
NO  
N/A  
YES  
YES  
YES

g. Does the facility transport residents to and from day training?  
Indicate the amount of income earned from providing such transportation during this reporting period.

NO  
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?  
Firm Name:  
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?  
If no, please explain.

NO  
N/A

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?  
Attach invoices and a summary of services for all architect and appraisal fees

YES

SEE ACCOUNTANTS' COMPILATION REPORT